**Open HIE SHR Community Call**

**Date: 23 September 2014**

**Attendees:**

Larry

Hannes

Pierre

Derek Ritz (ecGroup)

Ryan Crichton

Justin Fyfe

**Agenda:**

* Development update
* Feedback on alerting discussions - <https://wiki.ohie.org/display/documents/Alert+Transport+Proposals%3A+Pros+and+Cons>
* Update roadmap, what should this community be focusing discussion on for the coming months.
* AOB - please feel free to suggest any crucial topics
* CDC sponsored white paper

Recording of the meeting is available online for 30 days here: <http://www.conferenceplayback.com/stream/45491284/28756201.mp3>

**Minutes:**

**Development Update**

RC - update on SHR Ref application, Justin will talk on his work.

RC - working on the XDS.b record can provide and register transactions can store and retrieve documents from the SHR. As it is now is an end to end for the XDS.b. We don't have support for ATNA audit trail logging will want to do in the next few months but not critical. Will leave XDS.b module as it is. Focus on working on the mediators for the ....... ATNA audit logging will be the next high priority task.

DR - question about registry side, it includes repository as well?

RC - module only does repository actions need to set up registry alongside for OpenMRS. May want to do that for the future but may want to use existing tools.

DR - profiles we would expose would be the provide and register profile

RC - in XDS.b it would be provide and register and then retrieve

DR - Huge step forward and very impressed with the work RC and JF have done.

JF - been working on the on demand doc part. Got the code for  XDS.b module is able to receive a CDA doc break it apart to elements and then register a new on demand CCD doc for any patient for which it receives information. On the retrieve doc set when a client retrieves an on demand doc the module will create a CCD have vitals moving on to family history. Can generate APS document as well for pregnant women. .......

DR - is continuity of care a superset of the APS

JF - sections of the CCD can be used in the APS

DR - logical diagram on what if you do or don't have level 2 vs level 3 data

JF - every on demand doc registration and when the on demand is generated look at all the sections with the data and if all level 3 the document will be created. If missing data it will use the lowest level of CDA conformance received section by section

DR - implications that a system wide penalty will be if any clinic can only submit level 2 we will fall back to the lowest common denominator level

RC - level 2 content from level 3 is it something you already have stored or change level to level 3

JF - if there are level 3 capability then vital signs is textual and then discrete data. Merge two text sections together and it will say where the information comes from which visit. Can post samples of what have been working on.

DR - is it a requirement to include the text in a CDA

DR - remain totally off the hook impressed by the work being done

LL - agree easier to do it this way.

JF - the CDA import can obsolete previous data so when the weak clinic gets its level to level 3 the level 2 data can be replaced by the newer level 3 data

DR - dire consequence and because of that it may become an important requirement for a ministry to include a clinic in the network.

JF - what it falls back to is a text document with mark ups

DR - would make it difficult to use in the BPMN process

RC - level 3 would be a requirement for a deployment, would be for each deployment to consider and will impact how the rest of the HIE functions. Need to have some text on the implications of that

JF - could add it to the on demand document wiki page.

DR - doesn't allow for a progression from level 2 to level 3, not sure if you could obsolete the level 2 data. Could they resubmit the data to level 3 once they have it?

DR - to do ICP stuff users would have to enter computable data from the start

JF - the SHR would not automatically be able to

RC - could propose that you should start with level 3

DR - immediate benefit just to share information between caregivers. Should indicate that we could do event based at level 3 to fire off alerts. May not be able to do longitudinal record

JF - for APS the level two will eventually become level 3

LL - in general for our instances we enforce discrete data over documents, bar is high to get in the game and that is discrete data, have had a few stragglers it is a hindrance for smaller groups

DR - we are preparing ourselves for more heterogeneous environments that will be more difficult

JF - if OpenMRS can generate level 3 then it's a matter of choosing the options that generate level 3

DR - have to consider going into greenfields where we have to embrace existing systems

RC - documentation is an important aspect that we need to prepare for the November release one is for documentation and the second is for the software that implements those workflows. Need to work on documentation for this community of documentation we would need to inform others of. It would have to be the workflows we support and also implementation information

DR - behaviours of the systems is important, we are defining and engineering system behaviour for HIE which is more than the sum of its parts.

RC -also need to align with the other communities to align the documentation that we need to produce to make it coherent across communities.

**Feedback on alerting discussion**

RC - we had discussion on the mailing lists as well as a call. Shows lots of interest in doing this. Broke it down into two topics one being how to transport the messages and second how to structure the messages. Focused on the transport of messages and there are lots of options for what that could be.

Link to Carl Leitners doc on the proposals and the pros and cons for each.

4 different approaches suggested:

    1. AMQP standard queuing protocol - Carl has taken an applied to alerting

    2. Custom HTTP option

    3. SMTP and or Imap, mail protocols to do alerting and using mailboxes

    4. FHIR alert resource

Another call happening this week to continue the discussions, no clear idea on the winning proposal at the moment all have pros and cons

Using http or FHIR would be simple to get up and running with

SMTP and Imap would be a lot of profiling on how it would work

The FHIR alert is for clinical alerts

Each has pros and cons and still working through which is the best approach

DR - discussion was on what is easiest to program and what is easiest to implement they are not synonymous must note the differences between the two approaches

JF - mail servers are easy to set up but difficult to maintain and not a standard way to create a mailbox or delete an address. Maintenance including privacy is more difficult to ensure

JF - agree it’s not what is easy to program but also to maintain, need to be sure when we make a decision that it can be maintained and the accountability is in place.

DR - surprised that after the deep technical meeting there wasn't an agreement on the best choice. Suggest ranking the options 1-4 and get down to something that we can go with.

JF - perhaps a vote approach to choose one would be a good option, there isn't a clear cut option but they all have good aspects. Depends on how you want to look at the problem good point to pick one

DR - is the message we are sending needed to be a health medical message?

JF - should be able to structure the message and then have the receiver deliver it.

DR - if we expect to write to a repository it will have to be semantically understandable

RC - only FHIR describes both the transport and content what we gain in proposal four is both specification and you know they will work together well.

DR - must raise the point that the relevance of the content is being lost to the discussion on transport.

JF - careful that we need governance around sending out the information as well, with guidelines on how you manage the data

DR - we will probably need an ATNA log for each message being sent as well

**CDC-sponsored IHE white paper**

DR - conversation about the idea to weave into the IHE what the workflows are that it will support. At IHE you can submit white papers, we are submitting a white paper proposal to explore how ICP can be operationalized in an HIE and we could have funding support from CDC and a commitment of the work to be done by James Kariuki on this project.

There is an expectation that we will do some prototyping using OpenHIE as the exemplar for this idea.

Will use QRPH (quality, research and public health) as the place to house this work item and also making use of connections to the PCC (patient care coordination) and ITI (IT infrastructure) committees, since our exploration will necessarily touch those groups and the profiles they manage

Mid-term meeting at end of Feb for interim results, including prototyping -- and anticipating publication of white paper in June/July